



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

Steven Thompson

Respondent Name

Archer Daniels Midland Co

MFDR Tracking Number

M4-07-2094-01

Carrier's Austin Representative

Box Number 48

MFDR Date Received

November 22, 2006

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "PPO applied by Corvel. We no longer have PPO reductions w/ Corvel."

Amount in Dispute: \$1.99

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute received. However, no position statement submitted.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 16, 2006	99080 20610 J1030 J3490	\$1.99	\$1.99

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.202 sets out fee guidelines for professional medical services.
3. 28 Texas Administrative Code §129.5 sets reimbursement amount for work status reports.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 51 – Payment determined
 - W1 – No additional allowance recommended

Issues

1. Are the disputed services subject to a contractual agreement between the parties to this dispute?
2. Is the requestor entitled to reimbursement?

Findings

1. Review of the submitted documentation finds no information to support that the disputed services are

subject to a contractual agreement between the parties to this dispute.

2. 28 Texas Administrative Code §134.202(c)(1) states in pertinent part, "for service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Surgery, Radiology, and Pathology the conversion factor to be used for determining reimbursement in the Texas workers' compensation system is the effective conversion factor adopted by CMS multiplied by 125%.

28 Texas Administrative Code §129.5 (i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15.

28 Texas Administrative Code §134.503 (b) states, "For coding, billing, reporting, and reimbursement of prescription drugs and nonprescription drugs or over-the-counter medications, Texas workers' compensation system participants shall apply the provisions of Chapters 133 and 134 of this title (relating to General Medical Provisions and Benefits--Guidelines for Medical Services, Charges, and Payments, respectively).

(c) The insurance carrier shall reimburse the health care provider or pharmacy processing agent for prescription drugs the lesser of: (1) the fee established by the following formulas based on the average wholesale price (AWP) as reported by a nationally recognized pharmaceutical price guide or other publication of pharmaceutical pricing data in effect on the day the prescription drug is dispensed: (A) Generic drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.25) + \4.00 dispensing fee per prescription = reimbursement amount; (B) Brand name drugs: $((\text{AWP per unit}) \times (\text{number of units}) \times 1.09) + \4.00 dispensing fee per prescription = reimbursement amount; The Maximum Allowable Reimbursement will be calculated as follows;

Date of Service	Submitted Code	Billed Amount	MAR
March 16, 2006	99080 73	15.00	15.00 (per 28 Texas Administrative Code §129.5 (i))
March 16, 2006	20610	111.00	Physician fee schedule amount for Houston TX multiplied by 125% or $72.33 \times 125\% = \$90.41$
March 16, 2006	J1030	40.00	$(\text{AWP per unit}) \times (\text{number of units}) \times 1.09 + 4.00$ or $(5.079 \times 1) = 5.079 \times 1.09 = \$5.44 + 4 = \$9.44$
March 16, 2006	J3490	4.00	Unclassified drug no documentation to allow fee calculations
		\$170.00	\$114.85

The total MAR for the disputed services is \$220.30. The carrier previously paid \$105.88. The requestor is seeking \$1.99. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1.99.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1.99 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

August 21, 2014
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.